

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 11, 13, 14 Film G232 8-18-58 et

9008

Item 22 Film G232 8-21-58 et

CERTIFICATE OF DEATH

Reg. Dist. No.

69007

1. PLACE OF DEATH a. COUNTY Charles		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newburg, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Edwin	Middle Brazil	Last Brown
4. DATE OF DEATH	Month August	Day 7	Year 1958
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 4/58
9. AGE (In years lost birthday) yrs. Months	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. KIND OF BUSINESS OR INDUSTRY	12. BIRTHPLACE (State or foreign country) Newburg, Maryland
13. FATHER'S NAME Joseph Louis Wills	14. MOTHER'S MAIDEN NAME Grace Rebecca Brown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-4, 1958 to 8-7, 1958, that I last saw the deceased alive on 8-7, 1958, and that death occurred at 7:25 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) M.D. <i>Lorenzo Lopez, M.D.</i> Physician's Name. Hosp. La Plata Md. Physician's Memorial Hosp. La Plata Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8-7-58	22c. NAME OF CEMETERY OR CREMATORIUM Shiloh Cemetery
22d. LOCATION (City, town, or county) Shiloh, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE VS A15 (4) 1SM 10/57		24a. REC'D BY REGISTRAR DATE AUG 8 '58	24b. REGISTRAR'S SIGNATURE <i>Alfred Schuck</i>

4000212XV5

DEPARTMENT OF HOMELAND SECURITY
DEPARTMENT OF DEFENSE

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 9 Film Q233 9-11-58 et

09008

9009

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY

Charles

MARYLAND

CITY (If outside corporate limits, write RURAL
OR
end give nearest town)

TOWN

HOSPITAL OR
INSTITUTION OR
STREET ADDRESSLENGTH OF STAY
(in this place)

Life

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Md.

COUNTY

Charles

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN

STREET
ADDRESS

(If rural give location)

3. NAME OF
DECEASED
(Type or Print)

(First) William (Middle) D. (Last)

BUTLER Sr.

4. DATE (Month)
OF
DEATH

Aug 29

1958

5. SEX

M

6. COLOR OR
RACE

NEGRO

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

S

8. DATE OF BIRTH

Sept 17 1868

9. AGE last birthday

90 9/1

10. IF UNDER 1 YEAR

Months Days Hours Min.

10e. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Farmer

10b. KIND OF BUSINESS
OR INDUSTRY

Farming

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT
COUNTRY?

U.S.A.

13. FATHER'S NAME

Orsterius Butler

14. MOTHER'S MARRIED NAME

Elizabeth Ann Swann

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

None

17. INFORMANT & ADDRESS

William B. Butler Jr., Alton, IL

B-1
INTERVAL BETWEEN
ONSET AND DEATH

10 min.

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 IMMEDIATE CAUSE

(A)

Cirrhosis of liver.

ANTECEDENT CAUSE(S) DUE TO
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO
(B) (C)

Senile arterio-sclerotic disease

10 years.

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19e. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES NO 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
While
M. at work Not while
at work

21f. HOW DID INJURY OCCUR?

M.

22. I hereby certify that I attended the deceased from Alton, 1950, to 29 Aug 1958, that I last saw the deceased
alive on 21 Aug 1958, and that death occurred at 11:00 A.M. from the causes and on the date stated above.

SIGNATURE

Howard M.D.

ADDRESS (Street, city, town, state)

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

9/1/58

NAME OF CEMETERY OR CREMATORIAL

St. Ignatius

LOCATION (City, town, or county)

(State)

24. REC'D BY REGISTRAR

Arthur S. Klaus

25. FUNERAL DIRECTOR'S SIGNATURE

The Hunt Funeral Home, Webster, Md.

DATE SEP 4 '58

STATE OF MICHIGAN
DEPARTMENT OF STATE INSURANCE

CERTIFICATE OF DATA

2000

STATE OF MICHIGAN INSURANCE

DATA

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11931

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN lb 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Issue		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physician's Memorial						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Male	Col.		Cannady	August	29	19	58
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/26/58	9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Melvin Cannady				14. MOTHER'S MAIDEN NAME Agnes Hotor			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity INTERVAL BETWEEN ONSET AND DEATH 3 days DUE TO 776X Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)
21. I certify that I attended the deceased from 8-26 , 19 58 , to 8/29 , 19 58 that I last saw the deceased alive on 8/28/58 , 19 58 , and that death occurred at 4 A M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 8/29/58							
ACTUAL SIGNATURE <i>F. M. Johnson</i>		M.D.					
PHYSICIAN'S NAME (Type) F. M. Johnson, M.D.		La Plata, Md. 8/29/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 8/29/58	22c. NAME OF CEMETERY OR CREMATORIUM Holy Ghost			22d. LOCATION (City, town, or county) Issue, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Melvin Cannady, Father		ADDRESS		24a. REC'D BY REGISTRAR DATE DEC 15 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hause</i>	

16815

2017-01

2021-01

total east

total west

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9010 CERTIFICATE OF DEATH

Reg. Dist. No. 09009

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cobb Island		c. LENGTH OF STAY IN 1b 4 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cobb Island	
d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EDWARD Nathaniel		4. DATE OF DEATH DARCEY	Month August Day 21 Year 1958
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13, 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Somerset, Maryland
13. FATHER'S NAME Nathen Dorcey		14. MOTHER'S MAIDEN NAME Mary Stacks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 578-03-0351	17. INFORMANT (Son) Address Horace Darcey, 6112-N. 31st. Arlington, Va.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO acute cardiac dilation INTERVAL BETWEEN ONSET AND DEATH 10 min. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension (c) arteriosclerosis 10 yrs 20 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from the year of 1956 to 1958 that I last saw the deceased alive on 1957 , and that death occurred at 10:10A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>F. M. Johnson</i>	PHYSICIAN'S NAME (Type) <i>F. M. JOHNSON M.D.</i>	ADDRESS <i>La Plata, Md.</i>	DATE SIGNED <i>8-21-58</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Aug. 24, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Christ Church Cemetery	22d. LOCATION (City, town, or county) Wayside, Maryland (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arehart Funeral Home</i>	ADDRESS <i>Inc. La Plata, Maryland</i>	24a. REC'D BY REGISTRAR DATE <i>AUG 27 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>

STATE OF NEW YORK
CERTIFICATE OF DEATH

Name of deceased		Age at time of death		Cause of death	
John Doe		65 years		Diseased	
Address of deceased		Address of physician		Address of hospital	
123 Main Street		567 Hospital Street		890 Hospital Street	
City, State, Zip		City, State, Zip		City, State, Zip	
Albany, NY 12201		Albany, NY 12201		Albany, NY 12201	
Date of death		Time of death		Name of physician	
10/10/2023		10:00 AM		Dr. John Doe	
Signature of physician		Signature of hospital		Signature of coroner	
Dr. John Doe		Hospital Name		Coroner's Name	
Signature		Signature		Signature	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and detached as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9011 CERTIFICATE OF DEATH

09010

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Indian Head</i>		c. LENGTH OF STAY IN 1b <i>52 yrs</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Indian Head</i>	
d. STREET ADDRESS <i></i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Edward</i>		First <i>Russell</i>	Middle <i>Eastburn</i>
4. DATE OF DEATH <i>8 - 17</i>		Last <i>Sr</i>	Month Year <i>1958</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-11-98</i>
9. AGE (In years last birthday) <i>60</i>	10. IF UNDER 1 YEAR Months <i></i>	11. IF UNDER 24 HRS. Days <i></i>	12. IF UNDER 24 HRS. Hours <i></i>
13a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foremen - Mechanic</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Naval Powder Factory</i>	11. BIRTHPLACE (State or foreign country) <i>Hampton, Va</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>
13. FATHER'S NAME <i>Samuel</i>	14. MOTHER'S MAIDEN NAME <i>Lydie Smithson</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>	
16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Edward R. Eastburn Jr.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		Address <i>7402 Insley St. S.E. Washington 28. D. C.</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>Immediate</i>	
(b) DUE TO <i>Hypertensive Heart Disease</i>		14 yrs.	
(c) <i></i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>8/11</i> , 19 <i>58</i> , to <i>8/17</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>8/10</i> , 19 <i>58</i> , and that death occurred at <i>3 P.M.</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Frank G. Susan M.D.</i>		ADDRESS (Street, city or town, state) <i>5 Indian Head Ave</i>	
PHYSICIAN'S NAME (Type) <i>Frank G. Susan M.D.</i>		DATE SIGNED <i>8/17/58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>8-20-58</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Cedar Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Washington, D.C.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Summons Bros.</i>		24a. REC'D BY REGISTRAR DATE <i>Aug 19 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Trahan</i>

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09011

9012

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY		CHARLES	STATE		MD
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN		INDIAN HEAD	LENGTH OF STAY (in this place)		83 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS		1
3. NAME OF DECEASED (Type or Print)			4. DATE (Month) (Day) (Year) OF DEATH		
Henry			August 8 1958		
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	10. UNDER 1 YEAR Months Days Hours Min.
Male	Negro	Widowed	1874	84 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		
Laborer			Port Tobacco, MD		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Hawkins			Letta Gray		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY NO.		
No			216-12-4985		
17. INFORMANT & ADDRESS			3 Snobis Hawk St., Indian Head, MD		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			18. MEDICAL CERTIFICATION		
43IX IMMEDIATE CAUSE (A)			Acute Dystocarditis		
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B)					
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			Pyelo-Nephritis		
19a. DATE OF OPERATION			19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
21c. WHERE DID INJURY OCCUR? (City or town) (County)					
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)			21e. HOW DID INJURY OCCUR?		
M. at work			While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from July 3, 1958, to Aug 8, 1958, that I last saw the deceased alive on 8/8/58, and that death occurred at 3:15 P.M., from the causes and on the date stated above. SIGNATURE Frank G. Fisher M.D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)			DATE THEREOF		
Burial			8/12/58		
24. REC'D BY REGISTRAR			NAME OF CEMETERY OR CREMATORIAL REGISTRAR'S SIGNATURE		
DATE AUG 13 '58			ST Charles		
25. FUNERAL DIRECTOR'S SIGNATURE			LOCATION (City, town, or county) (State)		
			Indian Head, MD		
			The Hunt Funeral Home, Waldorf, MD.		

BY 350 MITJAS-INTJAS TO THE STATE OF TEXAS

STATE OF TEXAS

6102

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RECEIVED BY STATE OF TEXAS

RECEIVED

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SA, 100-1000-400

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55-10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

09012

CERTIFICATE OF DEATH

Reg. Dist. No.

9013

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Charles		MARYLAND		STATE Maryland		COUNTY Charles	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)		TOWN Indian Head Md	
TOWN Indian Head Md		41-Yrs		X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE (Month) (Day) (Year)			
Catherine Rebecca Jenkins				8-24-58 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	W-US	Married	2-18-1897	61 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (State or foreign country) Prince George County Maryland			
13. FATHER'S NAME George R. Coombs				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT & ADDRESS Thomas R. Jenkins-(Husband) Md.				14. MOTHER'S MAIDEN NAME Catherine A. Dixon			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 175.0 IMMEDIATE CAUSE (A) Circulatory Collapse 3-Hours ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) General Malignant Metastesis 8-Mths GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Adeno-Carcinoma - Adenocarcinoma Ovarian 1-Yr.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Marked Ascites 5-Mths							
19a. DATE OF OPERATION 7-11-57		19b. MAJOR FINDINGS OF OPERATION Cystic Ovary-Dr Vincent Hungerford, Providence Hospital Washington D.C.		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8-24-58, 19....., to 8-24-58, 19....., that I last saw the deceased alive on 8-24-58, 19....., and that death occurred at 8:30 AM, from the causes and on the date stated above. SIGNATURE <i>John Dever</i> ADDRESS (Street, city, town, state) <i>Indian Head Md</i> DATE SIGNED <i>8-25-58</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 8/26/1958		NAME OF CEMETERY OR CREMATORIAL St. Charles Church Cemetery		LOCATION (City, town, or county) Glymont, Charles, Md. (State)	
24. REC'D BY REGISTRAR DATE SEP 2 '58		REGISTRAR'S SIGNATURE Arthur S. Traas		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS AREHART FUNERAL HOME, INC. LA PLATA, MD.			

STATE OF NEW YORK - DEPARTMENT OF MOTOR VEHICLES

CERTIFICATE OF DEATH

REGISTRATION OF VEHICLE

REGISTRATION

STATE
REG.
NUMBER

REG.

REGISTRATION

REGISTRATION

CERTIFICATE OF DEATH

Reg. Dist. No.

9014

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>CHARLES</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN 1b <i>3 hours</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physicians Memorial</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>—</i>	Middle <i>—</i>	Last <i>JONES</i>
4. DATE OF DEATH <i>AUG 30 1958</i>	Month <i>AUG</i>	Doy <i>30</i>	Year <i>1958</i>
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>AUG 30 1958</i>
9. AGE (In years lost birthday) yrs. <i>—</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>infant</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	11. BIRTHPLACE (State or foreign country) <i>USA</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	13. FATHER'S NAME <i>Wm. W. Brown</i>		
14. MOTHER'S MAIDEN NAME <i>HELEN JONES</i>	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		
16. SOCIAL SECURITY NO. <i>—</i>	17. INFORMANT <i>Helen Jones</i>	Address <i>Respiratory failure</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>762.5</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			
INTERVAL BETWEEN ONSET AND DEATH <i>3 hrs.</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Prematurity</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour a. m. p. m. <i>Aug 30 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Aug 30, 1958</i> only to <i>Aug 30, 1958</i> that I last saw the deceased alive on <i>Aug 30, 1958</i> , and that death occurred at <i>2:30 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>F. M. Johnson M.D.</i>		ADDRESS (Street, city or town, state) <i>La Plata, Md.</i>	
PHYSICIAN'S NAME (Type) <i>F. M. Johnson M.D.</i>		DATE SIGNED <i>Aug 30, 58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/1/58</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Sacred Heart</i>
22d. LOCATION (City, town, or county) <i>La Plata, Md.</i>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ackart</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 9 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>
ADDRESS <i>La Plata, Md.</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9015

CERTIFICATE OF DEATH

09014

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) a. STATE Maryland b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicans Memorial Hospital		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARGARET	First S.	Middle JOHNS	Last KEY		
4. DATE OF DEATH August 3, 1958	Month August	Day 3	Year 1958		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 8, 1901		
9. AGE (In years at birthday) 57 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) La Plata, Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Columbas Norris	14. MOTHER'S MAIDEN NAME Mary Butler	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO			
16. SOCIAL SECURITY NO. ---		17. INFORMANT Mr. Hobart Key (Husband), La Plata, Maryland	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) DUE TO DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Nephritis failure Atherosclerosis of Liver		INTERVAL BETWEEN ONSET AND DEATH 8-1-58 1956			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19 Doy 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) La Plata	(County) Charles	(State) Md.
21. I certify that I attended the deceased from _____, 1956, to _____, 1958, that I last saw the deceased alive on _____, and that death occurred at _____, M, from the causes and on the date stated above. ACTUAL SIGNATURE F. J. Edelen M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/6/ 1958	22c. NAME OF CEMETERY OR CREMATORIUM Newtown Cemetery	22d. LOCATION (City, town, or county) Newtown, Charles County, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Archard Funeral Home, Inc., La Plata, Maryland		ADDRESS La Plata, Maryland	24a. REC'D BY REGISTRAR AUG 7 '58	24b. REGISTRAR'S SIGNATURE W. L. Smith	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

9016

09015

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Pages 1, 2 and 3 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1		Items 9, 11, 13, 23, 8/11/58										Reg. Dist. No.					
1. PLACE OF DEATH a. COUNTY		Charles Maryland					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)										
							b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		d. STREET ADDRESS		a. STATE		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Charles Cobb Island					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS		a. STATE		b. COUNTY				
							Charles Cobb Island		x		Charles Cobb Island		Md		Charles Cobb Island		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)							e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
							e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)		First		Middle		4. DATE OF DEATH		8		Month		6		Day		1958	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		Sept 9, 1882		9. AGE (In years less birthday)		70 yrs.		10. UNDER 1 YEAR Months		11. UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?											
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		DC.		U.S.A.											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (If no, go to item 16)		16. SOCIAL SECURITY NO.		17. INFORMANT		Elmer S. McGuigan 21/1911		Address									
18. CAUSE OF DEATH [Enter only one cause per line of (a), (b), and (c).]		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 8/6/58					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>										DATE SIGNED 8/6/58					
EXAMINER'S NAME (Type)		E. J. EDELEN															
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORI		22d. LOCATION (City, town, or county)		(State)									
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		Cedars Hill		Swindland		Md.									
VS. A15ME 5M 2/57		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		AUG 11 '58		W. Leach									
24. DATE		25. DATE															

DEATH NO.

NAME OF DECEASED

ADDRESS OF DECEASED

AGE OF DECEASED

SEX OF DECEASED

WEIGHT OF DECEASED

HEIGHT OF DECEASED

HAIR COLOR OF DECEASED

EYE COLOR OF DECEASED

SKIN COLOR OF DECEASED

HAIR LENGTH OF DECEASED

HAIR THICKNESS OF DECEASED

HAIR DENSITY OF DECEASED

HAIR SHAPE OF DECEASED

HAIR STYLING OF DECEASED

HAIR COMBING OF DECEASED

HAIR CUT OF DECEASED

HAIR DYE OF DECEASED

HAIR GEL OF DECEASED

HAIR SPRAY OF DECEASED

HAIR SHAMPOO OF DECEASED

HAIR LOTION OF DECEASED

HAIR OIL OF DECEASED

HAIR VITAMIN OF DECEASED

HAIR SERUM OF DECEASED

HAIR CREAM OF DECEASED

HAIR OINTMENT OF DECEASED

HAIR GEL OF DECEASED

HAIR SPRAY OF DECEASED

HAIR SHAMPOO OF DECEASED

HAIR LOTION OF DECEASED

HAIR OIL OF DECEASED

HAIR VITAMIN OF DECEASED

HAIR SERUM OF DECEASED

HAIR CREAM OF DECEASED

HAIR OINTMENT OF DECEASED

HAIR GEL OF DECEASED

HAIR SPRAY OF DECEASED

HAIR SHAMPOO OF DECEASED

HAIR LOTION OF DECEASED

HAIR OIL OF DECEASED

HAIR VITAMIN OF DECEASED

HAIR SERUM OF DECEASED

HAIR CREAM OF DECEASED

HAIR OINTMENT OF DECEASED

DEATH NO.

NAME OF DECEASED

ADDRESS OF DECEASED

AGE OF DECEASED

SEX OF DECEASED

WEIGHT OF DECEASED

HEIGHT OF DECEASED

HAIR COLOR OF DECEASED

EYE COLOR OF DECEASED

SKIN COLOR OF DECEASED

HAIR LENGTH OF DECEASED

HAIR THICKNESS OF DECEASED

HAIR DENSITY OF DECEASED

HAIR SHAPE OF DECEASED

HAIR STYLING OF DECEASED

HAIR COMBING OF DECEASED

HAIR CUT OF DECEASED

HAIR DYE OF DECEASED

HAIR GEL OF DECEASED

HAIR SPRAY OF DECEASED

HAIR SHAMPOO OF DECEASED

HAIR LOTION OF DECEASED

HAIR OIL OF DECEASED

HAIR VITAMIN OF DECEASED

HAIR SERUM OF DECEASED

HAIR CREAM OF DECEASED

HAIR OINTMENT OF DECEASED

HAIR GEL OF DECEASED

HAIR SPRAY OF DECEASED

HAIR SHAMPOO OF DECEASED

HAIR LOTION OF DECEASED

HAIR OIL OF DECEASED

HAIR VITAMIN OF DECEASED

HAIR SERUM OF DECEASED

HAIR CREAM OF DECEASED

HAIR OINTMENT OF DECEASED

HAIR GEL OF DECEASED

HAIR SPRAY OF DECEASED

HAIR SHAMPOO OF DECEASED

HAIR LOTION OF DECEASED

HAIR OIL OF DECEASED

HAIR VITAMIN OF DECEASED

HAIR SERUM OF DECEASED

HAIR CREAM OF DECEASED

HAIR OINTMENT OF DECEASED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9017

CERTIFICATE OF DEATH

Reg. Dist. No. 09016

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
Charles MARYLAND		Maryland b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Plaza		c. LENGTH OF STAY IN 1b 2 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Plains	
3. NAME OF DECEASED (Type or print)		First James	Middle Carroll
4. DATE OF DEATH		Month 8	Day 28
5. SEX		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 8-26-58		9. AGE (In years last birthday) yrs. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Edward L. Pickeral	
14. MOTHER'S MAIDEN NAME Mary Esther Adams		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. —		17. INFORMANT Edward L. Pickeral, White Plains, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 795.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH acute	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Hour o. m. p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from alive on		8-26, 1958, to 8-28, 1958, that I last saw the deceased M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 8-28-58	
ACTUAL SIGNATURE E. J. EDELEN		M.D.	
PHYSICIAN'S NAME (Type) E. J. EDELEN		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 8/28/58		22c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's	
22d. LOCATION (City, town, or county) Pomfret, Md.		23. FUNERAL DIRECTOR'S SIGNATURE The Hunt funeral Home, Waldorf, Md.	
24a. REC'D BY REGISTRAR DATE SEP 2 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9018

CERTIFICATE OF DEATH

09017

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md.		b. COUNTY Charles			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Indian Head		d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)		First Edward	Middle Wayne	Last PICKLE	4. DATE OF DEATH AUG 26	Month 1958	Day Year 19 58		
5. SEX M		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH 8-26-58	9. AGE (in years lost birthday) yrs. Months	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. Hours 6 20 Min.		
8. WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY —		14. MOTHER'S MAIDEN NAME Doris B. Pickeral		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —			
16. SOCIAL SECURITY NO. —		17. INFORMANT Robert Pickle, Indian Head Md.		Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7730 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		INTERVAL BETWEEN ONSET AND DEATH 4 hrs	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) La Plata	(County) Md.	(State) Md.			
21. I certify that I attended the deceased from 8-26, 1958, to 8-26, 1958, that I last saw the deceased alive on 8-26, 1958, and that death occurred at 7:30 P.M., from the causes and on the date stated above.		ACTUAL SIGNATURE F. M. JOHNSON MD		ADDRESS (Street, city or town, state) La Plata, Md.		DATE SIGNED 8-26-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 27, 1958		22c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's		22d. LOCATION (City, town, or county) Hampton			
23. FUNERAL DIRECTOR'S SIGNATURE Hawthorne Funeral Home, Waldorf, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE SEP 2 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kranz			

STATE OF NEW YORK
DEPARTMENT OF MOTOR VEHICLES
CERTIFICATE OF DEATH

1918

1918

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09018

9019

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Alton		c. LENGTH OF STAY IN 1b 5 Weeks Lifetime		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Physicians Memorial Hospital						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Alton			
3. NAME OF DECEASED (Type or print) George Arthur		First	Middle	Lost	4. DATE OF DEATH PILKERTON	Month August	Day 21	Year 1958	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1884	9. AGE (In years lost birthday) 74 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming self Emp.		11. BIRTHPLACE (State or foreign country) Charles County		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Columbus Pilkerton				14. MOTHER'S MAIDEN NAME Mamie E. Davis					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Leon Pilkerton (Son) Bel Alton, Maryland		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Cardiac Failure</i> DUE TO <i>420.1</i> 2 DAYS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Coronary Heart Disease</i> DUE TO <i>2 yrs.</i> (c) <i>Acute Perforation Duodenal Ulcer & Peritonitis</i> 6 DAYS									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>AUG. 15</i> , 1958, to <i>AUG. 21</i> , 1958, that I last saw the deceased alive on <i>AUG. 21</i> , 1958, and that death occurred at <i>5:20 A.M.</i> from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>J. Parran Jarboe</i>		ADDRESS (Street, city or town, state) <i>La Plata, Md.</i> DATE SIGNED <i>8-21-58</i>							
PHYSICIAN'S NAME (Type) <i>J. PARRAN JARBOE, M.D.</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug. 23, 1958		22c. NAME OF CEMETERY OR CREMATORIUM St. Thomas Cemetery		22d. LOCATION (City, town, or county) Chapel Point, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bel Alton Funeral Home, Inc.</i>		ADDRESS <i>La Plata, Md.</i> 24a. REC'D BY REGISTRAR DATE AUG 27 '58 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09019

9020

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. LENGTH OF STAY IN 1b <i>4 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physician Memorial Hospital</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Nanjemoy</i>	
d. STREET ADDRESS <i>1</i>		d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Minnie</i>		First <i>W.</i>	Middle <i>SANDERS</i>
3. NAME OF DECEASED (Type or print) <i>Minnie</i>		Lost <i></i>	4. DATE OF DEATH <i>AUG 8 1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>15 Sept 1875</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Berry W. Walter Mistle</i>	
14. MOTHER'S MÄIDEN NAME <i>Baxter</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	
16. SOCIAL SECURITY NO. <i></i>		17. INFORMANT <i>Worthy W. Sanders, Doncaster, Md.</i>	Address <i></i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hyperpyrexia</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO <i>Cerebral vascular accident.</i>		4 days	
(c) <i>Hypertension Cardio vascular disease</i>		years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>June</i> , 1948, to <i>8 Aug</i> , 1958, that I last saw the deceased alive on <i>8 August, 1958</i> , and that death occurred at <i>9:43 P.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Jawood Clinic</i> DATE SIGNED <i>8 Aug 58</i>			
ACTUAL SIGNATURE <i>Arthur O. Wooddy</i>		M.D.	
PHYSICIAN'S NAME (Type) <i>ARTHUR O. WOODDY, M.D. La Plata, Maryland</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22b. DATE THEREOF <i>8/10/58</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Chicamuxen M.E.</i>	
22d. LOCATION (City, town, or county) (State) <i>Chicamuxen, Md.</i>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>The Hunt Funeral Home, Waldorf, Md.</i>	
24a. REC'D BY REGISTRAR DATE <i>REG 12 1958</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur J. Grimes</i>	

MANHATTAN STATE PENITENTIARY - BUREAU OF

CERTIFICATE OF DEATH

1910

MANHATTAN



DEATH CERTIFICATE
MANHATTAN STATE PENITENTIARY - BUREAU OF
DEATHS
MANHATTAN, KANSAS
DECEMBER 1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

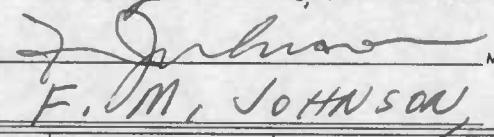
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9021

CERTIFICATE OF DEATH

Reg. Dist. No.

69020

1. PLACE OF DEATH a. COUNTY Charles		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b 5 Years		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Charles	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William		First	Middle	SCHAFFER		4. DATE OF DEATH Month AUGUST 28 Year 1958			
S. SEX <input checked="" type="checkbox"/>	6. COLOR OR RACE <input checked="" type="checkbox"/>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 13, 1894		9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Salesman	11. BIRTHPLACE (State or foreign country) Chicago, Ill.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Henry Schafer			14. MOTHER'S MAIDEN NAME Ann Howe						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 1 187-22-3093	17. INFORMANT Mrs. Virginia Schafer (Wife)		Address La Plata, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO atherosclerosis (c) DUE TO								INTERVAL BETWEEN ONSET AND DEATH immediate 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <u>May</u> , 19 <u>57</u> to <u>Aug 28, 1958</u> , that I last saw the deceased alive on <u>23 Aug, 1958</u> , and that death occurred at <u>1:20 P.M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE 	ADDRESS (Street, city or town, state) <u>La Plata, Md.</u>						DATE SIGNED <u>8-28-58</u>		
PHYSICIAN'S NAME (Type) F.M. JOHNSON, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL-Removal 8/30/58	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIUM Alagany Cemetery			22d. LOCATION (City, town, or county) Pittsburgh, Pennsylvania				
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC. LA PLATA, MARYLAND		ADDRESS AREHART Funeral Home, Inc. AREHART FUNERAL HOME, INC. LA PLATA, MARYLAND		24a. REC'D BY REGISTRAR DATE SEP 2 '58		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

THE GOVERNMENT OF THE STATE OF MARYLAND—BALTIMORE, 1861

COURT OF DEATH

1861



9022

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MD b. COUNTY Charles	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Benedict	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Benedict	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) IDA MAY TOYE		First	Middle
4. DATE OF DEATH	Month	Day	Year
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 15 1865
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> Months	11. IF UNDER 24 HRS. <input type="checkbox"/> Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY self	
10c. BIRTHPLACE (State or foreign country) Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Augustus Savoy		14. MOTHER'S MAIDEN NAME Susie Tyler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None 17. INFORMANT EVERETT TOYE Address Benedict Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		; YR.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Jan 24, 1957 to Aug 24, 1958 , that I last saw the deceased alive on Aug 24, 1958 , and that death occurred at 12: M EST , from the causes and on the date stated above. ACTUAL SIGNATURE J. PARRAN JARBOE M.D. PHYSICIAN'S NAME (Type) J. PARRAN JARBOE		ADDRESS (Street, city or town, state) La Plata, Md DATE SIGNED 8-25-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Aug 28 1958	22c. NAME OF CEMETERY OR CREMATORIAL St Peters
22d. LOCATION (City, town, or county) Waldorf Md (State)		24a. REC'D BY REGISTRAR DATE SEP 2 '58	
23. FUNERAL DIRECTOR'S SIGNATURE Hontt Funeral Home		ADDRESS Waldorf Md	24b. REGISTRAR'S SIGNATURE Charles S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9023

CERTIFICATE OF DEATH

Reg. Dist. No.

09022

1. PLACE OF DEATH a. COUNTY CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LA PLATA		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PHYSICIANS MEMORIAL HOSP.		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First John	Middle W.
4. DATE OF DEATH AUGUST 9 1958		Lost	Month Day Year
5. SEX Male		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 3 APRIL 1958		9. AGE (In years lost birthday) 4 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Howard E Trotter Jr		14. MOTHER'S MAIDEN NAME Mary M. Simpson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Howard E. Trotter Jr, Waldorf, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7545 DUE TO Respiratory failure		INTERVAL BETWEEN ONSET AND DEATH 10 min	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Congestive heart failure		3 wks.	
(c) DUE TO Congenital defect of heart		4 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3 April</u> , 1958, to <u>9 August</u> , 1958, that I last saw the deceased alive on <u>9 August</u> , 1958, and that death occurred at <u>10:30</u> P.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Waldorf, MD LA PLATA, MARYLAND DATE SIGNED 10 Aug 58	
ACTUAL SIGNATURE ARTHUR O. WOODY		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 8/12/58		22c. NAME OF CEMETERY OR CREMATORIAL ST Peters	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		22d. LOCATION (City, town, or county) Waldorf, Md. (State)	
ADDRESS 2066 333 XV4		24a. REC'D BY REGISTRAR AUG 13 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

DEPARTMENT OF PUBLIC SAFETY - FIRE DEPARTMENT
CERTIFICATE OF DEATH

W. J. Dorn

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

09023

1. PLACE OF DEATH a. COUNTY CHARLES		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) La Plata		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) INSTITUTION Physicians Memorial Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Faulkner	
3. NAME OF DECEASED (Type or print) Lola		d. STREET ADDRESS 1	
4. DATE OF DEATH August 23 1958		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female		6. COLOR OR RACE Negro	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH ? 1900 58	
WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wesley Brown		14. MOTHER'S MAIDEN NAME Josephine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Randolph Whalen, Newburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.0		INTERVAL BETWEEN ONSET AND DEATH 12 hrs.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Respiratory Collapse Metastasis of Carcinoma of bladder 5 years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 18 Aug 1958 to 23 Aug 1958 that I last saw the deceased alive on 23 Aug 1958 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Arthur O. Woody		ADDRESS (Street, city or town, state) La Plata, Md. DATE SIGNED 23 Aug 58	
PHYSICIAN'S NAME (Type) ARTHUR O. WOODY			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 8/26/58	
22c. NAME OF CEMETERY OR CREMATORIAL John Wesley		22d. LOCATION (City, town, or county) Chaptico, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, Waldorf, Md.		24a. REC'D BY REGISTRAR DATE SEP 2 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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